

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

14073

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14081

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LaPlata		c. LENGTH OF STAY IN 1b 08-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicians Memorial Hospital		d. STREET ADDRESS 08-1	
3. NAME OF DECEASED (Type or print) HERBERT Dyer ADAMS		4. DATE OF DEATH Month Day Year October 13 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 23 1902
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Adams		14. MOTHER'S MAIDEN NAME Catherine Coombs	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-12-8259	
17. INFORMANT Herbert Adams		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumothorax and interstitial emphysema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rupture of emphysematous bleb DUE TO (c) Blunt injury to chest		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver in auto-auto collision	
20c. TIME OF INJURY Month, Day, Year 3:25 p.m. 10/10 19 66		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Clinton Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Petty		M.D.	
EXAMINER'S NAME (Type) Charles S. Petty, M.D.		22. DATE SIGNED 10/13/66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 15, 1966	
23c. NAME OF CEMETERY OR CREMATORY Mt. Rest		23d. LOCATION (City or town) (County) (State) La Plata, Chas. Md.	
24. FUNERAL DIRECTOR The Hunt Funeral Home, Waldorf, Md.		25a. REC'D BY REGISTRAR DATE OCT 18 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

15041

10

FOR STATE HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14082

1. PLACE OF DEATH a. COUNTY Charles b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata c. LENGTH OF STAY IN 1b 08-1 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicians Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newberg d. STREET ADDRESS 08-1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CALVIN L. CLARK		4. DATE OF DEATH Month Day Year 10 31 19 66	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG 17, 1965
9. AGE (In years last birthday) 1		10. IF UNDER 1 YEAR Months Days Hours Min. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		11. BIRTHPLACE (State or foreign country) WASH., D.C.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME THOMAS C. CLARK	
14. MOTHER'S MAIDEN NAME GLORIA MARIE COOPER		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address GLORIA MARIE COOPER, Newburg, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Craniocerebral injury 904.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Allegedly fell INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Allegedly fell	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 10 ? 19 66		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Newberg Charles Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz EXAMINER'S NAME (Type) WERNER U. SPITZ, M.D.		22. DATE SIGNED 11-1-66 CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-2-66	
23c. NAME OF CEMETERY OR CREMATORY SHILOH Meth		23d. LOCATION (City or Town) (County) (State) SHILOH, CHARLES, Md.	
24. FUNERAL DIRECTOR ARCHART FUNERAL Home, LA PLATA, Md.		25. REC'D BY REGISTRAR DATE NOV 7 1966	
26. REGISTRAR'S SIGNATURE Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1985

CERTIFICATE OF DEATH

Reg. Dist. No.

14083

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland, h. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Indian Head		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt 1 Box 50 In car and beside car		d. STREET ADDRESS Rt. 1 Box 13	
3. NAME OF DECEASED (Type or print) First Middle Last Margaret Virginia Dodson		4. DATE OF DEATH Month Day Year October 24th, 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 5, 1906
9. AGE (In years last birthday) yrs. 60		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC	
11. BIRTHPLACE (State or foreign country) Lynchburg, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Smith		14. MOTHER'S MAIDEN NAME Estell McKINNEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. BERNARD DODSON, Address	
17. INFORMANT Husband INDIAN HEAD, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism (Presumptive) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardiovascular disease (Under the care of Dr. Fredrick Johnson) DUE TO (c) Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE IMMEDIATE CAUSE GIVEN IN PART I (a) Laurel, Md.			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 24, 1966 , to Same day, 1966 , that I last saw the deceased alive on October 24, 1966 , and that death occurred at 1:00P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Alexander L. Russell, M.D.		DATE SIGNED 10-24-66	
PHYSICIAN'S NAME (Type) Alexander L. Russell, M.D.		Indian Head, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-27-66	
22c. NAME OF CEMETERY OR CREMATORY TRINITY MEMORIAL		22d. LOCATION (City, town, or county) (State) WALDORF, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Md.		24a. REC'D BY REGISTRAR OCT 31 1966	
24b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR TO FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

14088

Name of Deceased		Christie	
Sex		Female	
Age		30 years	
Date of Death		Aug. 1, 1900	
Place of Death		Home, 101 N. 1st St., Baltimore, Md.	
Cause of Death		Diphtheria	
Duration of Illness		10 days	
Occupation		None	
Marital Status		Single	
Place of Birth		Maryland	
Signature of Physician		J. H. Jones, M.D.	
Signature of Registrar		W. H. Smith, M.D.	
Signature of Coroner		J. H. Jones, M.D.	
Signature of Burial Officer		J. H. Jones, M.D.	
Signature of Undertaker		J. H. Jones, M.D.	
Signature of Minister		J. H. Jones, M.D.	
Signature of Family		J. H. Jones, M.D.	
Signature of Friends		J. H. Jones, M.D.	
Signature of Neighbors		J. H. Jones, M.D.	
Signature of Community		J. H. Jones, M.D.	
Signature of State		J. H. Jones, M.D.	
Signature of Nation		J. H. Jones, M.D.	
Signature of World		J. H. Jones, M.D.	

14088

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14084

1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CHARLES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LA PLATA</u>		c. LENGTH OF STAY IN lb <u>3 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PHYSICIANS MEMORIAL HOSPITAL</u>		e. STREET ADDRESS <u>100 HAWTHORNE DRIVE</u>	
3. NAME OF DECEASED (Type or print) <u>HAROLD</u> First <u>JOSEPH</u> Middle <u>DOUTT</u> Last		4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>29</u> Year <u>1966</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 2, 1918</u>
9. AGE (In years last birthday) <u>48</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dealer Sales Rep.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ESSO-Humble Oil</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>W. Moreland County</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Oscar H. Douth</u>		14. MOTHER'S MAIDEN NAME <u>Laura McCoy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW 11 176-09-8281</u>	
17. INFORMANT <u>La Plata, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Collapse</u> 2001 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia, non specific, metastatic</u> DUE TO (c) <u>Lymphosarcoma, generalized</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>4 day</u> <u>5 month</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June, 1966</u> , to <u>29 Oct, 1966</u> , that (I) (we) last saw the deceased alive on <u>October 29, 1966</u> , and that death occurred at <u>4:30 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Arthur O. Woody, MD</u>		22b. DATE SIGNED <u>29 Oct-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>ARTHUR O. WOODY</u>		22d. ADDRESS <u>JARWOOD CLINIC LA PLATA, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov. 2, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Ignatius Cemetery, Bel Alton, Charles, Md.</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR ADDRESS <u>Arehart Funeral Home Inc., La Plata, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 7 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1991

5211

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14085 CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Charles b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LaPlata Md c. LENGTH OF STAY IN 1b 4-Hours d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Physicians Memorial LaPlata Md						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LaPlata Md d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) (Triplet #2) Dyson						4. DATE OF DEATH 10-25-66 19 19					
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-25-66		9. AGE (In years last birthday) 4 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Charles County Maryland				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Mayo Dyson Conner						14. MOTHER'S MAIDEN NAME Mary Louise Brown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mother Mary L. Dyson, Bryans Road Md					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity (5-Month Gestation) 776 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) This was the second of triplets, premature, lived 4-Hrs										INTERVAL BETWEEN ONSET AND DEATH 4-Hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from 10-25-66 , 19 19 , to 10-25-66 19 19 , that (I) (we) last saw the deceased alive on 10-23-66 19 19 , and that death occurred at 4:30 PM from the causes and on the date stated above.											
22a. SIGNATURE [Signature] M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) James E. Andrews MD						22d. ADDRESS Indian Head Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation				23b. DATE THEREOF 10/30/1966		23c. NAME OF CEMETERY OR CREMATORY Arehart Funeral Home		23d. LOCATION (City, town or county) (State) La Plata, Md.			
24. FUNERAL DIRECTOR ADDRESS Arehart Funeral Home, Inc.-La Plata, Md.						25a. REC'D BY REGISTRAR DATE NOV 7 1966		25b. REGISTRAR'S SIGNATURE [Signature]			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Charles					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LaPlata Md					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LaPlata Md				
c. LENGTH OF STAY IN 1b 4-Hrs.					d. STREET ADDRESS Physicians Memorial LaPlata Md				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Physicians Memorial LaPlata Md					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last (Triplet #3) Dyson					4. DATE OF DEATH Month Day Year 10-25-66 19				
5. SEX Female		6. COLOR OR RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-25-66		9. AGE (In years last birthday) Months Days Hours Min. 4-Hrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Charles County Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Mayo Dyson/ Conner Dyson					14. MOTHER'S MAIDEN NAME Mary Louise Brown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mother- Mary L. Dyson Bryans Road Md					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity (five month Gestation) 776X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 4-Hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) This was the third of triplets born and lived about 4-Hrs								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)					
21. I certify that (I) (this hospital) attended the deceased from 10-25-66 , 19__, to 10-25-66 , 19__, that (I) (we) last saw the deceased alive on 10-25-66 , and that death occurred at 4:30 PM from the causes and on the date stated above.									
22a. SIGNATURE [Signature]					22b. DATE SIGNED 4-26-66				
22c. PHYSICIAN'S NAME (Type) James E. Andrews MD					22d. ADDRESS Indian Head Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 10/30/1966		23c. NAME OF CEMETERY OR CREMATORY Arehart Funeral Home		23d. LOCATION (City, town or county) (State) La Plata, Md.			
24. FUNERAL DIRECTOR ADDRESS Arehart Funeral Home, Inc.-La Plata, Md					25a. REC'D BY REGISTRAR DATE NOV 7 1966				
25b. REGISTRAR'S SIGNATURE [Signature]									

6-223953

14087

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

14085

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14087

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata				c. LENGTH OF STAY IN 1b D.O.A.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) La Plata Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last THOMAS Delmas (Bee) ELLIS				4. DATE OF DEATH Month Day Year October 16, 19 66			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 6, 1907	
9. AGE (In years last birthday) yrs. 59		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Service				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Abell, Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Thomas Dent Ellis				14. MOTHER'S MAIDEN NAME Mary Ella Bailey			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Maureen Ellis Address same as # 2 above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> October 17, 1966 Address (Street, city, town, or county)			
22. DATE SIGNED							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 20, 1966		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery		23d. LOCATION (City or Town) (County) (State) Bushwood, Maryland	
24. FUNERAL DIRECTOR ADDRESS W. Clarke Mattingley Leonardtown, Maryland				25. REC'D BY REGISTRAR DATE OCT 21 1966			
25b. REGISTRAR'S SIGNATURE Charles Judge							

1894

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

14086

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14088

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LaPlata			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Alton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicians Memorial Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First THOMAS Middle ANTHONY Last FENWICK				4. DATE OF DEATH Month October Day 22 Year 19 66			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 30, 1966		9. AGE (In years lost birthday) yrs. 4	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) La Plata, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Leroy Fenwick				14. MOTHER'S MAIDEN NAME Pearl Viola Yates			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address Pearl Yates-Mother- Bel Alton, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemophilus influenzae, Meningitis and Empyema 340.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Charles S. Petty</i>		EXAMINER'S NAME (Type) Charles S. Petty, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)		22. DATE SIGNED 10/23/66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct, 25, 1966		23c. NAME OF CEMETERY OR CREMATORY St. Ignatius		23d. LOCATION (City or Town) (County) (State) Chapel Point, Charles, Md.	
24. FUNERAL DIRECTOR ADDRESS Arehart Funeral Home Inc., La Plata, Md.				25a. REC'D BY REGISTRAR DATE OCT 26 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
14087 CERTIFICATE OF DEATH 14089									
1. PLACE OF DEATH a. COUNTY Charles County MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LaPlata Md			c. LENGTH OF STAY IN 1b 3-Days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Indian Head Md				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Physicians Memorial LaPlata Md					d. STREET ADDRESS 38-Raymond Ave			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Virginia Ella Haislip					Last		4. DATE OF DEATH Month 10-28-66 Day 19 Year 19		
5. SEX Female		6. COLOR OR RACE W-US		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-10-1875		9. AGE (In years last birthday) 91 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK			10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC			11. BIRTHPLACE (County & State, or foreign country) Nanjemoy Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Chandler					14. MOTHER'S MAIDEN NAME Josephine E. Todd				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 218-14-3791-0		17. INFORMANT 4601-Buterworth Place NW Elizabeth H. Colbert, Daughter Washington				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) Arterio-Sclerosis General								INTERVAL BETWEEN ONSET AND DEATH Indefinite Indefinite Indefinite	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Aging Process								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 10-26-66, 19__, to 10-28-66, 19__, that (I) (we) last saw the deceased alive on 10-26-66, 19__, and that death occurred at 7:45 PM from the causes and on the date stated above.									
22a. SIGNATURE James E. Andrews MD					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-29-66		
22c. PHYSICIAN'S NAME (Type) James E. Andrews MD					22d. ADDRESS Indian Head Md				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 1, 1966		23c. NAME OF CEMETERY OR CREMATORY Old Durham		23d. LOCATION (City, town or county) (State) Tronsides, Md.			
24. FUNERAL DIRECTOR The Hunt Funeral Home, Waldorf, Md.					25a. REC'D BY REGISTRAR DATE NOV 2 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VR A15ME
3500 4-64

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH					14090						
1. PLACE OF DEATH a. COUNTY Charles MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) e. STATE Maryland b. COUNTY Charles						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata			c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Doncaster						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicans Memorial Hospital					d. STREET ADDRESS 08-1			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HOMER Middle BRYAN Last HAMMACK					4. DATE OF DEATH Month 10 Day 21 Year 1966						
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 26, 1900		9. AGE (In years last birthday) 66 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumer			10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) Doncaster, Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Homer Benson Hammock					14. MOTHER'S MAIDEN NAME Mary Cofer						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 215-18-0238		17. INFORMANT Mrs. Lucy Hammock-Wife Address Box 250 Indian Head,						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4201 DUE TO Ext. Heart Dis Conditions, If any, which gave rise to immediate cause (e), stating the underlying cause last. (b) ? DUE TO (c) ?										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year 69/10/21/66			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Doncaster, Charles, Md				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE E. J. EDELEN					22. DATE SIGNED 10-21-66						
EXAMINER'S NAME (Type) E. J. EDELEN					DEPUTY MEDICAL EXAMINER La Plata, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 10/24/1966		23c. NAME OF CEMETERY OR CREMATORY Chicamuxen Methodist Cemetery			23d. LOCATION (City, town or county) (State) Chicamuxen, Md.			
24. FUNERAL DIRECTOR Arehart Funeral Home, Inc.-La Plata, Md.					25a. REC'D BY REGISTRAR OCT 25 1966		25b. REGISTRAR'S SIGNATURE Charles Judge				

FOR STATE
JAN 19 1961

RECEIVED BY NATIONAL BUREAU OF INVESTIGATION
FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE

100-111111

[Faint, mostly illegible text and markings, possibly a form or document, with some handwritten notes and stamps.]

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

14091

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head</u>		c. LENGTH OF STAY IN 1b <u>14 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Mamie</u> Middle <u>Dolly</u> Last <u>Hart</u>		4. DATE OF DEATH Month <u>October</u> Day <u>15</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 9, 1893</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Powder Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Naval Prop. Plant</u>	
11. BIRTHPLACE (State or foreign country) <u>Chickamauga, Ga.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joseph M. Hart</u>		14. MOTHER'S MAIDEN NAME <u>Jennie E. Simmons</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-30-0615</u>	
17. INFORMANT <u>Edna Greenfield</u>		Address <u>Indian Head, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> <u>154X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Metastatic Carcinoma Rectal</u> DUE TO (c) <u>Diabetes Mellitus</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>14 yrs</u> <u>14 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan, 1960</u> , to <u>Oct. 15, 1966</u> , that I last saw the deceased alive on <u>Oct. 14, 1966</u> , and that death occurred at <u>11:50 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank A. Susan</u> M.D.		ADDRESS (Street, city or town, state) <u>Rt. 1 Box 50</u>	
PHYSICIAN'S NAME (Type) <u>Frank A. Susan M.D.</u>		DATE SIGNED <u>10/15/66</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 19, 1966</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Charles</u>		22d. LOCATION (City, town, or county) (State) <u>Glymont, Charles Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arehart Funeral Home Inc., La Plata, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 20 1966</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text, possibly "John Doe"]</p>		<p>2. SEX [Faint text, possibly "Male"]</p>	
<p>3. AGE [Faint text, possibly "45 years"]</p>		<p>4. DATE OF BIRTH [Faint text, possibly "10-15-1880"]</p>	
<p>5. PLACE OF BIRTH [Faint text, possibly "Baltimore, Md"]</p>		<p>6. OCCUPATION [Faint text, possibly "Teacher"]</p>	
<p>7. CAUSE OF DEATH [Faint text, possibly "Heart Disease"]</p>		<p>8. PLACE OF DEATH [Faint text, possibly "Home"]</p>	
<p>9. DATE OF DEATH [Faint text, possibly "11-1-1918"]</p>		<p>10. TIME OF DEATH [Faint text, possibly "10:00 AM"]</p>	
<p>11. SIGNATURE OF PHYSICIAN [Faint signature]</p>		<p>12. SIGNATURE OF REGISTRAR [Faint signature]</p>	
<p>13. NAME OF PHYSICIAN [Faint text, possibly "Dr. J. H. Smith"]</p>		<p>14. NAME OF REGISTRAR [Faint text, possibly "J. H. Jones"]</p>	
<p>15. ADDRESS OF PHYSICIAN [Faint text, possibly "123 Main St, Baltimore, Md"]</p>		<p>16. ADDRESS OF REGISTRAR [Faint text, possibly "456 Main St, Baltimore, Md"]</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
14090					CERTIFICATE OF DEATH			14092	
1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>			c. LENGTH OF STAY IN lb <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cobb Island</u> <u>081</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Physicans Memorial Hospital</u>					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ERNA</u> <u>MILLER</u>					4. DATE OF DEATH Month Day Year <u>October</u> <u>4</u> , <u>19</u> <u>66</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 20, 1892</u>		9. AGE (In years last birthday) yrs. <u>74</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>New York, New York</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>(Unkown) Schmidt</u>					14. MOTHER'S MAIDEN NAME <u>Martha Rictor</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>056-26-0323</u>		17. INFORMANT <u>Mr. Frank J. Miller-Husband</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>Generalized Arteriosclerotic Heart Disease</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 minute</u> <u>5 Years</u> <u>5 Years</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>4 March, 1966</u> to <u>4 Oct</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4 Oct</u> 19 <u>66</u> , and that death occurred at <u>8:10 P.M.</u> from causes and on the date stated above.									
22a. SIGNATURE <u>Arthur O. Wooddy, M.D.</u>					22b. DATE SIGNED <u>6 Oct. 1966</u>			22c. PHYSICIAN'S NAME (Type) <u>Arthur O. Wooddy, M.D.</u>	
22d. ADDRESS <u>La Plata, Maryland</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/7/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Christ Church Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Wayside, Maryland</u>		
24. FUNERAL DIRECTOR <u>Arehart Funeral Home, Inc.-La Plata, Md.</u>					25a. REC'D BY REGISTRAR <u>OCT 10 1966</u>		25b. REGISTRAR'S SIGNATURE <u>f Charles Judge</u>		

14028

14028

RECEIVED
OCT 10 1964
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA PLATA c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicians Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROBERT JOHN ROBITSKI		4. DATE OF DEATH Month October Day 14 Year 1966	
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 2 1898
9. AGE (In years last birthday) 68 yrs. IF UNDER 1 YEAR: Months 68 Days 68 Hours 68 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NEWSPAPER CARRIER - WASH. POST.	
11. BIRTHPLACE (County & State, or foreign country) Richmond Co., New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Robitski		14. MOTHER'S MAIDEN NAME Mary Buffala	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. YES	
17. INFORMANT Staton Island, N.Y. 10314		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5810 Chlorosis of Liver DUE TO (b) Chlorosis of Liver Conditions, if any, which gave rise to immediate causa (a), stating the underlying cause last. DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9/1 1966 , to 10/14/1966 , that (I) (we) last saw the deceased alive on 10/14/1966 , and that death occurred at 7:30 M., from the causes and on the date stated above.			
22a. SIGNATURE E.J. EDELEN M.D.		22b. DATE SIGNED 10/15/1966	
22c. PHYSICIAN'S NAME (Type) E.J. EDELEN M.D.		22d. ADDRESS La Plata, Maryland 20646	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 18, 1966	
23c. NAME OF CEMETERY OR CREMATORY Pisgah Methodist		23d. LOCATION (City, town or county) (State) Pisgah, Charles Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Arehart Funeral Home Inc., La Plata, Md.		25a. REC'D BY REGISTRAR OCT 20 1966	
25b. REGISTRAR'S SIGNATURE f Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT.

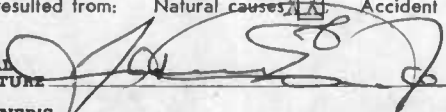
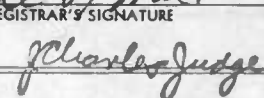
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any copy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and any event within 72 hours after death.

VR A15ME
SM 1/63

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14092

14094

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) La Plata				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Owings Mills			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Physicians Memorial Hosp.				d. STREET ADDRESS 35 Kingsley Rd.			
3. NAME OF DECEASED (Type or print) William Arthur Seal, Jr.				4. DATE OF DEATH Oct. 27 19 66			
5. SEX Male		6. COLOR OR RACE Cauc		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 7-24-1918	
9. AGE (In years last birthday) 48 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Project Supervisor-Comm.Instal.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME William Arthur Seals Sr.				14. MOTHER'S MAIDEN NAME Marietta Wolf			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 213-03-6814			
17. INFORMANT Ann N. Seal				Address 35 Kingsley Rd., Owings Mills, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion-Massive DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis- General DUE TO (c) Aging Process							INTERVAL BETWEEN ONSET AND DEATH Immediate Indefinite Indefinite
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE 				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JAMES E. Andrews, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED Oct. 27, 1966			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF October 31, 1966		22c. NAME OF CEMETERY OR CREMATORY Annul Ridge Center, Pikesville 8, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR Frank H. Newell, Pikesville 8, Md.				24a. REC'D BY REGISTRAR NOV 1 1966			
				24b. REGISTRAR'S SIGNATURE 			

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FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If daily delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #G382 10/26/66 pc

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14093

14095

1. PLACE OF DEATH a. COUNTY CHARLES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata c. LENGTH OF STAY IN lb Waldorf d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicians Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Clara Caroline SHLAGEL		4. DATE OF DEATH Month Day Year October 17 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 1, 1903
9. AGE (In years lost birthday) 62 03/ yrs.		IF UNDER 1 YEAR Months Days Hours Min. 62 03/ yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Manager		10b. KIND OF BUSINESS OR INDUSTRY Dairy Store	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Ebert		14. MOTHER'S MAIDEN NAME Grace Weingart	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-42-7451	
17. INFORMANT Frances Klingenmaier, York, Penn.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate EXAMINER'S NAME (Type) Charles S. Springate, M.D.		22. DATE SIGNED October 18, 1966 CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-20-66	
23c. NAME OF CEMETERY OR CREMATORY St Peters Cemetery		23d. LOCATION (City or Town) (County) (State) Waldorf, Md.	
24. FUNERAL DIRECTOR Huntt Funeral Home, Waldorf, Md.		25a. REC'D BY REGISTRAR DATE OCT 21 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION

14002

TO DEPUTY MEDICAL EXAMINER: This certificate should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and to any event within 72 hours after death.

VR A15ME (5)
6M 1/66

1 (M)
FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15561

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LaPlata Md		c. LENGTH OF STAY IN 1b 84	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Henrietta Thomas		4. DATE OF DEATH Month 10 -Day 25 -Year 66	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-14-1882
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. INDUSTRY At Home	
13. FATHER'S NAME Benjamin Marshall		14. MOTHER'S MAIDEN NAME Mary Jane Hawkins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-56-0259	
17. INFORMANT Daughter Ruth Frederick, LaPlata Md		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA- DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) Aging Process		INTERVAL BETWEEN ONSET AND DEATH 24-Hrs Indefinite Indefinite	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Had been in a coma since 10-23-66		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James E. Andrews M.D.		22. DATE SIGNED 10-26-66	
EXAMINER'S NAME (Type) James E. Andrews MD, Indian Head Md		22. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL/CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/29/1966	
23c. NAME OF CEMETERY OR CREMATORY St. Pauls Church Cemetery- Waldorf, Md.		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Arehart Funeral Home, Inc.-La Plata, Md.		25. REC'D BY REGISTRAR NOV 9 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

15201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

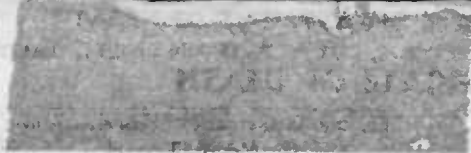
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1. PLACE OF DEATH a. COUNTY Charles b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) La Plata c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Physicans Memorial Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bryans Road d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last LODGE MARCELOUS WRIGHT				4. DATE OF DEATH Month Day Year October 12, 1966			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 11, 1883		9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fire Marshall-Retired U.S.N.P.P.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wesley M. Wright				14. MOTHER'S MAIDEN NAME Mary A. (Unkown)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. Yes		17. INFORMANT Address Bryans Road, Md Mr. William E. Wright-Son, Box 84, Rt. #1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arr - 4033 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Arteriosclerotic Gangrene 2nd 6p DUE TO (c) Septicemia Streptococci gram -						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hem. Plasia 2nd - Smiling						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July 66 , 19..., to 12 Oct , 19 66 , that (I) (we) last saw the deceased alive on 12 Oct , 19 66 , and that death occurred at 3 P.M. , from the causes and on the date stated above.							
22a. SIGNATURE Miller L. L. Chy.				22b. DATE SIGNED 13/10/66			
22c. PHYSICIAN'S NAME (Type) M. Ivan C. Cohey				22d. ADDRESS Box 387 La Plata Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/15/1966	23c. NAME OF CEMETERY OR CREMATORY Nanjemoy Baptist Cemetery, Nanjemoy, Md.		23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR'S SIGNATURE Arehart Funeral Home, Inc. - La Plata, Md.				25a. REC'D BY REGISTRAR DATE OCT 18 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

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